SERFF Tracking Number:	*AEGG-125671896*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39279*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*TLIC - STOP LOSS APPLICATION*		
Project Name/Number:	*TLIC - STOP LOSS APPLICATION/TLIC - STOP LOSS APPLICATION*		

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: TLIC - STOP LOSS APPLICATION	SERFF Tr Num: AEGG-125671896	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 39279
Sub-TOI: H21.000 Health - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Donna Lambert	Disposition Date: 06/13/2008
	Date Submitted: 06/11/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: TLIC - STOP LOSS APPLICATION	Status of Filing in Domicile: Not Filed
Project Number: TLIC - STOP LOSS APPLICATION	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: Resubmission	Previous Filing Number: 35602
Group Market Size:	Overall Rate Impact:
Group Market Type:	Filing Status Changed: 06/13/2008
	State Status Changed: 06/13/2008
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

The attached application was approved by your Department on April 10, 2007, State Filing Number 35602. We have added the notice required by Bulletin 6-2008. A certification is attached, and the $20 filing fee is submitted via EFT.

Sincerely,

Donna Lambert

501-227-1639

SERFF Tracking Number:	*AEGG-125671896*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39279*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*TLIC - STOP LOSS APPLICATION*		
Project Name/Number:	*TLIC - STOP LOSS APPLICATION/TLIC - STOP LOSS APPLICATION*		

djlambert@aegonusa.com

Company and Contact

Filing Contact Information

Donna Lambert, Contract Analyst	djlambert@aegonusa.com
PO Box 8063	(800) 400-3042 [Phone]
Little Rock, AR 72203-8063	(501) 227-1097[FAX]

Filing Company Information

Transamerica Life Insurance Company	CoCode: 86231	State of Domicile: Iowa
PO Box 8063	Group Code: 468	Company Type: Life and Health
Little Rock, AR 72203-8063	Group Name:	State ID Number:
(501) 227-1106 ext. [Phone]	FEIN Number: 39-0989781	

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	$20.00	06/11/2008	20795559

SERFF Tracking Number:	*AEGG-125671896*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39279*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*TLIC - STOP LOSS APPLICATION*		
Project Name/Number:	*TLIC - STOP LOSS APPLICATION/TLIC - STOP LOSS APPLICATION*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/13/2008	06/13/2008

SERFF Tracking Number:	*AEGG-125671896*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39279*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*TLIC - STOP LOSS APPLICATION*		
Project Name/Number:	*TLIC - STOP LOSS APPLICATION/TLIC - STOP LOSS APPLICATION*		

Disposition

Disposition Date: 06/13/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGG-125671896*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39279*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*TLIC - STOP LOSS APPLICATION*		
Project Name/Number:	*TLIC - STOP LOSS APPLICATION/TLIC - STOP LOSS APPLICATION*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Bulletin 6-2008 App Notice Revision	Approved-Closed	Yes
Form	Application for Excess Loss Insurance	Approved-Closed	Yes

SERFF Tracking Number:	*AEGG-125671896*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39279*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*TLIC - STOP LOSS APPLICATION*		
Project Name/Number:	*TLIC - STOP LOSS APPLICATION/TLIC - STOP LOSS APPLICATION*		

Form Schedule

Lead Form Number: SL40A (3/07)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SL40A (3/07)	Application/ Enrollment Form	Application for Excess Loss Insurance	Revised	Replaced Form #: SL40A (3/07 Previous Filing #: 35602	50	APP-TLIC-SL40A_07app for filing.pdf

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company
[Administrative Office: P.O. Box 34310, Louisville, KY 40232-4310]
Phone: [1-800-XXX-XXXX]

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by Transamerica Life Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: *ABC Company*
Address (street, city, state, and zip): *123 Any Street, Anytown, USA 22222*
Key Contact: *John J. Doe* Telephone: *(555) 555-5555* Tax ID: *51-55555*
Applicant is a: ☒ Corporation ☐ Labor Union ☐ Partnership ☐ Proprietorship ☐ Other: _____
Nature of Business of the Group to be Insured: *Banking*

{Total number of eligible lives: Employees *100* Dependents *75* Retirees *0* }
Requesting retiree coverage? ☐ YES ☒ NO
Requested Effective Date: *1/1/2007*

Affiliates or Subsidiaries: *N/A*

Addresses of Affiliates or Subsidiaries: *N/A*

SPECIFIC EXCESS LOSS INSURANCE: ☒ YES ☐ NO
Benefit Period: [Covered Expenses Incurred from *10/01/2006* through *12/31/2007*,
and Paid from *01/01/2007* through *12/31/2007*. ; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, Covered Expenses must be Incurred from *10/01/2006* through the termination date and Paid from *01/01/2007* through the termination date to be eligible for reimbursement.
{Covered Expenses Incurred from *10/1/2006* through *12/31/2006* will be limited to *$15,000* per ☒ Covered Person {☐ Family.}}]
Specific Deductible per ☒ Covered Person {☐ Family}: [$*25,000]*
Specific Percentage Reimbursable: *100*%
Maximum Specific Benefit Per Covered Person {per Lifetime}(including Specific Deductible):
☐ $500,000 ☒ $1,000,000 ☐ $2,000,000 ☐ Other $_____

Covered Expenses under Specific Excess Loss: [☐ Medical ☒ Medical with Stand Alone Prescription Drug Program]
{Common Accident Provision: ☐ Yes ☒ No}

Specific Premium Rates per Month {[See item i on page 2 of application for special conditions]}		
{[Employee	Number of lives: 100	$ 32.50]}
{[Employee & Spouse	Number of lives: 125	$ 63.75]}
{[Employee & Child	Number of lives: 150	$ 65.00]}
{[Family	Number of lives: 175	$ 81.25]}

{[1. Specific Expedited Reimbursement Endorsement: ☐ YES ☒ NO}
{2. Specific Terminal Liability Endorsement: ☐ YES ☒ NO $_____}
{3. Aggregating Specific Deductible Endorsement: ☐ YES ☒ NO $_____}
{4. Other Endorsement: _____ ☐ YES ☒ NO $_____]}

{Minimum Annual Specific Premium *$1,500.00*}

AGGREGATE EXCESS LOSS INSURANCE: ☒ YES ☐ NO

Benefit Period: [Covered Expenses Incurred from *10/01/2006* through *12/31/2007*,
and Paid from *01/01/2007* through *12/31/2007*; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, no reimbursement will be made under Aggregate Excess Loss Insurance.
{Covered Expenses Incurred from *10/01/2006* through *12/01/2006* will be limited to *$125,000* or *N/A %* of the Annual Aggregate Deductible.}]
Covered Expenses under Aggregate Excess Loss Coverage: {[☒ Medical ☒ Medical with Stand Alone Prescription Drug Program
☐ Dental ☐ Vision ☐ Weekly (Disability) Income ☐ Other (Please Specify) _____]}

Aggregate Percentage Reimbursable: *100%*
Maximum Aggregate Benefit: ☐ $500,000 ☒ $1,000,000 ☐ Other $_____

Minimum Annual Aggregate Deductible: [$*NA* or *100*% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.]

Loss Limit per Covered Person $ *25,000*

Aggregate Excess Loss Premium: ☒ Monthly ☐ Annually [*$400.00*]

{[1. Aggregate Terminal Liability Endorsement: ☐ YES ☒ NO $_____]}

{[2. Aggregate Accommodation Endorsement: ☐ YES ☒ NO $_____]}

{[3. Other Endorsement: _____ ☐ YES ☒ NO $_____]}

Monthly Aggregate Factors								
	[Medical	# of lives	Prescription Drugs	# of lives	Dental	# of lives		#of lives]
[Employee	195.00	100	85.00	100				
Dependent	560.00	175	95.00	175				
								]

Full Name of Third Party Administrator: *CDE Administrator*
Address: (street, city, state, and zip): *321 Main Street, Anytown USA 99999*
Key Contact: *Jane Jones* Telephone: *(555) 555-5555*

Agent or Broker: *Joe Agent*
SS No. or Tax ID: *555-55-5555*
Address: *111 Main Street, Anytown USA 99999*

It is understood and agreed by the undersigned that:

a. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document describing the benefits provided by the Plan which shall be kept on file in the office of the Company. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company. In the event of a material variance, in the judgement of the Company, between the Plan Document received by the Company and the Plan benefit provisions upon which the terms and rates of the Aggregate and Specific Excess Loss Coverage were based, any Policy that has been issued will not take effect unless a Plan Document is received, accepted, and on file in the Company's office.

b. The undersigned will provide or employ a Third Party Administrator (TPA) to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the TPA is the undersigned's agent and that statements and answers given by the TPA are binding on the undersigned.

c. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such premium to the undersigned.

d. Any Aggregate and/or Specific Excess Loss Insurance shall be described in the Policy issued.

e. Experience, census, and other information contained in the underwriting information as furnished by the Applicant directly, or through its representative, are the primary data elements on which the Company's proposal was based. The undersigned will provide any additional underwriting information required by the Company.

f. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including underwriting requirements, have been met and the required premiums paid.

g. The undersigned represents that the statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document accurately and completely reflect the true facts. The undersigned understands that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations are part of this Application.

h. The Company will evaluate the undersigned's risk, and may require adjustments of rates, factors, and/or special limitations to accommodate for abnormal risks.

i. Other: _____

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant:_____

Signature of Authorized Person: _____

Print Name:_____Title:_____

Date: _____

Signature of Agent or Broker:_____

Print Name of Agent or Broker:_____

ARKANSAS

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

ALASKA

"A person who knowingly and with intent to injure, defraud, or deceive an insurance company files claim containing false, incomplete, or misleading information may be prosecuted under state law."

ARIZONA

"**For your protection, Arizona law requires the following statement to appear on this form**. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties".

ARKANSAS, LOUISIANA, TEXAS and WEST VIRGINIA

"Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

CALIFORNIA

For your protection California law requires the following to appear on this form.

"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison".

COLORADO

"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading fact of information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement for award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

DELAWARE, IDAHO, and INDIANA

"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a state of claim containing any false, incomplete or misleading information is guilty of a felony."

DISTRICT OF COLUMBIA

"WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

FLORIDA
"Any person who knowingly and with intent to injure, defraud, or deceive any Insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a Felony of the Third Degree."

KENTUCKY
"Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

MAINE
"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

MINNESOTA
"A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

NEW HAMPSHIRE
"Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638:20."

NEW JERSEY
"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

NEW MEXICO
"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

OHIO
"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

OKLAHOMA
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA
"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

TENNESSEE, MAINE, and VIRGINIA
"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

ALL OTHER STATES

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

SERFF Tracking Number:	*AEGG-125671896*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39279*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*TLIC - STOP LOSS APPLICATION*		
Project Name/Number:	*TLIC - STOP LOSS APPLICATION/TLIC - STOP LOSS APPLICATION*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGG-125671896*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39279*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*TLIC - STOP LOSS APPLICATION*		
Project Name/Number:	*TLIC - STOP LOSS APPLICATION/TLIC - STOP LOSS APPLICATION*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 06/13/2008
Comments:
Attachments:
Reg 19 Certification.pdf
Reg 49 Certification.pdf

Satisfied -Name: Application
Review Status: Approved-Closed 06/13/2008
Comments:
Attachment:
APP-TLIC-SL40A_07app for filing.pdf

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 06/13/2008
Bypass Reason: Not applicable to this filing.
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 06/13/2008
Bypass Reason: Not applicable to this filing.
Comments:

Satisfied -Name: Bulletin 6-2008 App Notice Revision
Review Status: Approved-Closed 06/13/2008
Comments:
Attachment:
AR SL APP REFILING 6-11-08.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Transamerica Life Insurance Company

Form Number(s): SL40A (3/07)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Patsy J. Napier, FLMI, AIRC, HIA, CCP
Name

Assistant Secretary
Title

6/11/2008
Date

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Transamerica Life Insurance Company

Form Titles: Application for Excess Loss Insurance

Form Numbers: SL40A (3/07)

I hereby certify that to the best of my knowledge and belief, the above forms and submission comply with Arkansas Regulation 49, relative to the dissemination of life and health guaranty association notices.

Officer Signature

Patsy J. Napier, FLMI, AIRC, HIA, CCP

Name of Officer

Assistant Secretary

Officer Title

June 11, 2008

Date

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company
[Administrative Office: P.O. Box 34310, Louisville, KY 40232-4310]
Phone: [1-800-XXX-XXXX]

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by Transamerica Life Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: *ABC Company*
Address (street, city, state, and zip): *123 Any Street, Anytown, USA 22222*
Key Contact: *John J. Doe* Telephone: *(555) 555-5555* Tax ID: *51-55555*
Applicant is a: ☒ Corporation ☐ Labor Union ☐ Partnership ☐ Proprietorship ☐ Other: _____
Nature of Business of the Group to be Insured: *Banking*

{Total number of eligible lives: Employees *100* Dependents *75* Retirees *0* }
Requesting retiree coverage? ☐ YES ☒ NO
Requested Effective Date: *1/1/2007*

Affiliates or Subsidiaries: *N/A*

Addresses of Affiliates or Subsidiaries: *N/A*

SPECIFIC EXCESS LOSS INSURANCE: ☒ YES ☐ NO
Benefit Period: [Covered Expenses Incurred from *10/01/2006* through *12/31/2007*,
and Paid from *01/01/2007* through *12/31/2007*. ; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, Covered Expenses must be Incurred from *10/01/2006* through the termination date and Paid from *01/01/2007* through the termination date to be eligible for reimbursement.
{Covered Expenses Incurred from *10/1/2006* through *12/31/2006* will be limited to *$15,000* per ☒ Covered Person {☐ Family.}}]
Specific Deductible per ☒ Covered Person {☐ Family}: [$*25,000]*
Specific Percentage Reimbursable: *100*%
Maximum Specific Benefit Per Covered Person {per Lifetime}(including Specific Deductible):
☐ $500,000 ☒ $1,000,000 ☐ $2,000,000 ☐ Other $_____

Covered Expenses under Specific Excess Loss: [☐ Medical ☒ Medical with Stand Alone Prescription Drug Program]
{Common Accident Provision: ☐ Yes ☒ No}

Specific Premium Rates per Month {[See item i on page 2 of application for special conditions]}		
{[Employee	Number of lives: 100	$ 32.50]}
{[Employee & Spouse	Number of lives: 125	$ 63.75]}
{[Employee & Child	Number of lives: 150	$ 65.00]}
{[Family	Number of lives: 175	$ 81.25]}

{[1. Specific Expedited Reimbursement Endorsement: ☐ YES ☒ NO}
{2. Specific Terminal Liability Endorsement: ☐ YES ☒ NO $_____}
{3. Aggregating Specific Deductible Endorsement: ☐ YES ☒ NO $_____}
{4. Other Endorsement: _____ ☐ YES ☒ NO $_____]}

{Minimum Annual Specific Premium *$1,500.00*}

AGGREGATE EXCESS LOSS INSURANCE: ☒ YES ☐ NO

Benefit Period: [Covered Expenses Incurred from *10/01/2006* through *12/31/2007*,
and Paid from *01/01/2007* through *12/31/2007*; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, no reimbursement will be made under Aggregate Excess Loss Insurance.
{Covered Expenses Incurred from *10/01/2006* through *12/01/2006* will be limited to *$125,000* or *N/A %* of the Annual Aggregate Deductible.}]
Covered Expenses under Aggregate Excess Loss Coverage: {[☒ Medical ☒ Medical with Stand Alone Prescription Drug Program
☐ Dental ☐ Vision ☐ Weekly (Disability) Income ☐ Other (Please Specify) _____]}

Aggregate Percentage Reimbursable: *100%*
Maximum Aggregate Benefit: ☐ $500,000 ☒ $1,000,000 ☐ Other $_____

Minimum Annual Aggregate Deductible: [$*NA* or *100*% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.]

Loss Limit per Covered Person $ *25,000*

Aggregate Excess Loss Premium: ☒ Monthly ☐ Annually [*$400.00*]

{[1. Aggregate Terminal Liability Endorsement: ☐ YES ☒ NO $_____]}

{[2. Aggregate Accommodation Endorsement: ☐ YES ☒ NO $_____]}

{[3. Other Endorsement: _____ ☐ YES ☒ NO $_____]}

Monthly Aggregate Factors								
	[Medical	# of lives	Prescription Drugs	# of lives	Dental	# of lives		#of lives]
[Employee	195.00	100	85.00	100				
Dependent	560.00	175	95.00	175				
								]

Full Name of Third Party Administrator: *CDE Administrator*
Address: (street, city, state, and zip): *321 Main Street, Anytown USA 99999*
Key Contact: *Jane Jones* Telephone: *(555) 555-5555*

Agent or Broker: *Joe Agent*
SS No. or Tax ID: *555-55-5555*
Address: *111 Main Street, Anytown USA 99999*

It is understood and agreed by the undersigned that:

a. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document describing the benefits provided by the Plan which shall be kept on file in the office of the Company. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company. In the event of a material variance, in the judgement of the Company, between the Plan Document received by the Company and the Plan benefit provisions upon which the terms and rates of the Aggregate and Specific Excess Loss Coverage were based, any Policy that has been issued will not take effect unless a Plan Document is received, accepted, and on file in the Company's office.

b. The undersigned will provide or employ a Third Party Administrator (TPA) to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the TPA is the undersigned's agent and that statements and answers given by the TPA are binding on the undersigned.

c. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such premium to the undersigned.

d. Any Aggregate and/or Specific Excess Loss Insurance shall be described in the Policy issued.

e. Experience, census, and other information contained in the underwriting information as furnished by the Applicant directly, or through its representative, are the primary data elements on which the Company's proposal was based. The undersigned will provide any additional underwriting information required by the Company.

f. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including underwriting requirements, have been met and the required premiums paid.

g. The undersigned represents that the statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document accurately and completely reflect the true facts. The undersigned understands that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations are part of this Application.

h. The Company will evaluate the undersigned's risk, and may require adjustments of rates, factors, and/or special limitations to accommodate for abnormal risks.

i. Other: _____

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant:_____

Signature of Authorized Person: _____

Print Name:_____Title:_____

Date: _____

Signature of Agent or Broker:_____

Print Name of Agent or Broker:_____

ARKANSAS

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

ALASKA

"A person who knowingly and with intent to injure, defraud, or deceive an insurance company files claim containing false, incomplete, or misleading information may be prosecuted under state law."

ARIZONA

"**For your protection, Arizona law requires the following statement to appear on this form**. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties".

ARKANSAS, LOUISIANA, TEXAS and WEST VIRGINIA

"Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

CALIFORNIA

For your protection California law requires the following to appear on this form.

"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison".

COLORADO

"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading fact of information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement for award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

DELAWARE, IDAHO, and INDIANA

"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a state of claim containing any false, incomplete or misleading information is guilty of a felony."

DISTRICT OF COLUMBIA

"WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

FLORIDA
"Any person who knowingly and with intent to injure, defraud, or deceive any Insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a Felony of the Third Degree."

KENTUCKY
"Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

MAINE
"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

MINNESOTA
"A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

NEW HAMPSHIRE
"Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638:20."

NEW JERSEY
"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

NEW MEXICO
"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

OHIO
"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

OKLAHOMA
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA
"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

TENNESSEE, MAINE, and VIRGINIA
"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

ALL OTHER STATES

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TRANSAMERICA
WORKSITE MARKETING

Administrative Office:
P.O. Box 8063
LIttle Rock, AR 72203-8063
Telephone: (888) 763-7474

Transamerica Occidental Life Insurance Company
Transamerica Life Insurance Company
Monumental Life Insurance Company
Life Investors Insurance Company of America

Company Name: Transamerica Life Insurance Company

Form Titles: Application for Excess Loss Insurance

Form Numbers: **SL40A (3/07)**

I hereby certify that the application named above has not been changed in any way except the addition of the notice required by Arkansas Bulletin 6-2008.

Patsy J. Napier, FLMI, AIRC, HIA, CCP
Assistant Secretary

June 11, 2008
Date